ORTHOPAEDIC ASSOCIATES

Doctor: ______________________ Patient ID #: ______________________

PATIENT INFORMATION

Name: ______________________ Sex: ☐ M ☐ F Date of Birth: __________ Age: ______

Address: ______________________ Social Security #: ______________________

______________________ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Race: ☐ White ☐ Black ☐ Hispanic ☐ Other

City, State, Zip: ______________________

Phone: ______________ ☐ Home ☐ Work ☐ Cell Referring Physician: ______________________

Phone: ______________ ☐ Home ☐ Work ☐ Cell Primary Care Physician: ______________________

EMERGENCY CONTACT: Name: ______________________

Relationship: ______________________ Phone: ______________________

PATIENT'S EMPLOYMENT INFORMATION ☐ Employed ☐ Retired ☐ Student ☐ Other

Employer / School: ______________________ Employer / School Phone: ______________________

Employer Address: ______________________ City, State, Zip: ______________________

GUARANTOR INFORMATION ☐ Same as Patient

Relationship to Patient: ______________________

Name: ______________________ Employer: ______________________

Address: ______________________ Phone: ______________ ☐ Home ☐ Work ☐ Cell

______________________ Social Security #: ______________________

City, State, Zip: ______________________ Date of Birth: ______________

PRIMARY INSURANCE INFORMATION

☐ Health ☐ Liability ☐ Other

Insured Party: ______________________

Insured Phone: ______________________

Relationship to Patient: ______________________

Social Security #: ______________________

Insured's Date of Birth: ______________________

Insured's Employer: ______________________

Insurance Company: ______________________

Insured's ID: ______________________

Policy Group #: ______________________

SECONDARY INSURANCE INFORMATION

☐ Health ☐ Liability ☐ Other

Insured Party: ______________________

Insured Phone: ______________________

Relationship to Patient: ______________________

Social Security #: ______________________

Insured's Date of Birth: ______________________

Insured's Employer: ______________________

Insurance Company: ______________________

Insured's ID: ______________________

Policy Group #: ______________________

WORKER'S COMPENSATION INFORMATION

Mail Claims To: ☐ Insurance Carrier ☐ Employer

Insurance Carrier Name: ______________________ Phone: ______________________

Address: ______________________ Contact Person: ______________________

______________________ Claim #: ______________________

City, State, Zip: ______________________ Employer at Time of Injury: ______________________

I authorize ORTHOPAEDIC ASSOCIATES to perform treatment deemed by the physician in exercise of professional judgment to be of appropriate kind and method on me / my dependent. I hereby authorize ORTHOPAEDIC ASSOCIATES to release any information acquired in my examination or treatment to any insurer, government agency providing benefits, or to anyone for charges.

SIGNED: X ______________________ DATE: ______________

I hereby assign to and authorize payment to ORTHOPAEDIC ASSOCIATES all benefits payable under the terms of any insurance policy listed above. I realize the insurance, workers compensation and/or liability claims may not pay the entire bill. I agree to pay the difference or the entire bill if necessary. I also agree to pay costs of collection, including attorney's fees and waive my exemption under the constitution and laws of the state of Georgia.

SIGNED: X ______________________ DATE: ______________

If you want to exercise any of these rights, please contact our Privacy Officer. All requests must be submitted to us in writing on a designated form (which we will provide to you), and returned to the attention of our Privacy Officer at the address below.

Contact Information and How to Report a Privacy Rights Violation.

If you have questions and/or would like additional information regarding the uses and disclosures of your Health Information, you may contact our Privacy Officer at:

Address: 619 Pointe North Blvd
Albany, GA 31721

Attn: Privacy Officer

Telephone: (229)883-4707

Fax: (229)435-1038

If you believe that your privacy rights have been violated or that we have violated our own privacy practices, you may file a complaint with us. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at Region IV, Office for Civil Rights, U.S. Dept. of Health and Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsyth Street, SW, Atlanta, GA 30303-8909. Complaints filed directly with the Secretary must be made in writing, name us, describe the acts or omissions in violation of the Privacy Rules or our privacy practices, and must be filed within 180 days of the time you knew or should have known of the violation. Complaints submitted directly to us must be in writing and to the attention of our Privacy Officer. There will be no retaliation for filing a complaint.

The Effective Date of this Privacy Notice is ____April 14,__________, 2003.

BY SIGNING BELOW, I HEREBY ACKNOWLEDGE RECEIPT OF THIS PRIVACY NOTICE.

______________________________ ______________
Printed Name of Patient Date

____
Signature of Patient or Patient's Representative

____
Printed Name of Patient's Representative (*if applicable*)

____
Representative's Relationship to Patient (*if applicable*)

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To be completed by Orthopaedic Associates:

After a good faith attempt to obtain an Acknowledgment of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s) ______________________
____
____

______________________________ ______________
Signature of Orthopaedic Associates' Representative Date

ORTHOPAEDIC ASSOCIATES, INC.
Medical History Form

Appointment Date:________ With Dr.________ Chart #:________

Patient Name:________ Age:____ Sex: ☐ F ☐ M Height:____ Wt.:____

ALLERGIC TO ANY MEDICATIONS? ☐ No ☐ Yes List allergies:________

____

Please explain reason for this visit. Please list involved body parts, and comment on whether you have pain, numbness, weakness, swelling, stiffness, or other symptoms:

____

____

How long ago did this start?________ **How did you hurt yourself?**________

Did you go to the Emergency Room? ☐ No ☐ Yes **Date of E.R. visit:**________

Were Xrays taken? ☐ No ☐ Yes **From which hospital:** ☐ Phoebe ☐ Palmyra ☐ Other:________

Were you injured for this problem on the job? ☐ No ☐ Yes

What treatments have you tried thus far?

☐ medications	☐ physical therapy	☐ brace
☐ cane / crutch	☐ injections	☐ chiropractic treatment

☐ Surgery for this same problem? Please list procedure, surgeon and date:________

Current Work Status: ☐ Regular ☐ Light Duty ☐ Not Working Now ☐ Disabled ☐ Retired ☐ Student

When is the last date you worked at your regular job?________

Workers Comp? ☐ No ☐ Yes

PAST MEDICAL HISTORY

Do you have, or have you ever had, any of the following? (Check all that apply.)

☐ Heart Disease	☐ Stroke	☐ Hepatitis / Jaundice
☐ High Blood Pressure	☐ Kidney Problems or Failure	☐ HIV / AIDS
☐ Diabetes Controlled with: ☐ Insulin ☐ Pills ☐ Diet	☐ Seizures	☐ Asthma / Emphysema
☐ High Cholesterol	☐ Cancer: where?	☐ Ulcer ☐ Acid Reflux
☐ Blood Clot	☐ Depression	☐ Thyroid Disease
☐ Anemia ☐ Bleeding Disorder	☐ Osteoporosis	☐ Rheumatoid Arthritis

Surgeries (check all that apply, and list below those not outlined here):

☐ Appendectomy ☐ Tonsillectomy ☐ Gallbladder ☐ Hysterectomy ☐ Cataracts ☐ Hernia

ORTHOPAEDIC ASSOCIATES, INC.

Medical History Form, page 2 **Patient Name:**____________________

Please list your current medications, both prescription and over-the-counter:

FAMILY HISTORY

Has any blood relative ever had? (Check all that apply.)

☐ Asthma ☐ Diabetes ☐ High Cholesterol

☐ Bleeding Problem ☐ Hypertension ☐ Kidney Disease

☐ Cancer; type:____________________ ☐ Heart Disease ☐ Stroke

☐ Other:____________________

SOCIAL HISTORY

Do you use tobacco? ☐ No ☐ Yes If "Yes", packs per day:__________ ☐ Informed of smoking risk?

Alcohol use? ☐ No ☐ Yes If "Yes", how often? ☐ Daily ☐ Other:__________ drinks / week

Marital Status: ☐ M ☐ S ☐ D ☐ W **Education** (Years / Degree):__________

Occupation:____________________ ☐ Student

Employer:____________________

REVIEW OF SYSTEMS

Have you **had** any of these symptoms? Please circle all that apply:

System	Symptoms	
Constitutional / General	Fever, Weight Gain, Weight Loss, Change of Appetite	☐ None
Eyes	Blurred Vision, Double Vision, Vision Loss	☐ None
ENT	Deafness, Sinusitis, Hoarseness, Vertigo, Trouble Swallowing	☐ None
Cardiovascular	Chest Pain, Palpitations, Irregular or Rapid Heart Beats, Murmur	☐ None
Respiratory	Shortness of Breath, Wheezing, Chronic Cough, Spitting up Blood	☐ None
Digestive	Heartburn / Ulcers, Nausea / Vomiting, Blood in Stool, Hepatitis / Liver Disease, Constipation or Diarrhea	☐ None
Urologic	Pain with Urination, Incontinence, Hesitancy, Bleeding	☐ None
Gynecologic	Breast Masses, Pain, Discharge, Date of Last Exam: __________	☐ None
Skin	Rashes, Lesions That Do Not Heal, Change in Moles	☐ None
Neurologic	Seizures, Loss of Balance / Coordination, Paralysis, Weakness, Memory Loss	☐ None
Psychiatric	Depression, Anxiety, Hallucinations, Sleep Disturbances	☐ None
Endocrine	Excessive Thirst, Excessive Urination, Heat or Cold Intolerance	☐ None
Blood / Lymphatics	Anemia, Bleeding Tendencies, Swollen Nodes	☐ None
Allergic / Immunologic	Hives / Itching, Eczema	☐ None
Musculoskeletal	Stiffness, Joint Pain or Deformity, Muscle Wasting, Gout, Rheumatoid Arthritis	☐ None

Please sign indicating that the information provided is accurate to the best of your knowledge:

____

Patient Signature Date

____

Physician Signature Date